

# Coconino County Community Health Improvement Plan

A Communitywide Approach to Public Health

October 2014

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## Executive Summary

The Coconino County Public Health Service District (CCPHSD) held two meetings with service providers, one in the Northern Hub of the County, Page, and one in the Southern Hub, Flagstaff. These meetings were held in order to develop a Coconino County Community Health Improvement Plan, a plan that is intended to guide all public health and related organizations in the county. The meetings drew together 71 experts in the fields of Injury, chronic illness including diabetes, heart disease, obesity and access to health care. Providers were asked to identify current activities in these areas, service gaps, strategies needed to eliminate these gaps, and the role that CCPHSD should play.

Participants in both sessions identified strategies for addressing health concerns and service gaps, including health education, stakeholder engagement, training for providers and more. When asked about the CCPHSD role, participants stated that the CCPHSD should act as a coordinator between service providers, an educator of the public, an advocate for systems change, and a documenter of health care opportunities.

Subsequent to the sessions, numerous changes occurred at the CCPHSD and these changes have affected both the priorities and the role of CCPHSD in implementing the Coconino County Community Health Improvement Plan. The plan is to reconvene the group before August, 2015 and revise goals and strategies as needed.

## Introduction

In the summer of 2012, the CCPHSD embarked upon a community health improvement process. The community health improvement process, as defined by the National Association of County and City Health Officers, concerns the whole public health *system*. This process includes “the way in which the activities of many organizations contribute to community health improvement.” Importantly, the community health improvement process is not for the health department alone. The CCPHSD has a separate strategic plan that is aligned with and supports the Coconino County Community Health Improvement Plan but is limited to the CCPHSD roles and goals (see Appendix D).

A community health improvement process includes two parts. The CCPHSD completed the first part, the Coconino County Community Health Assessment (CHA), in December of 2012. The CHA summarizes data about the health status of Coconino County residents and includes data on communicable diseases, chronic diseases, causes of death, demographics and more. It also includes the results of surveys and focus groups among county residents in which residents were asked about perceived health priorities for their communities. The CHA can be found on the Coconino County website.

After completing the CHA, the CCPHSD began working on the second part of the process, the Community Health Improvement Plan (CHIP). The purpose of the CHIP was to gather stakeholders and “identify priority issues, develop and implement strategies for action, and establish accountability.” This document summarizes the results of the CHIP portion of the planning process.

The CHIP participants made explicit their wish to continue meeting to discuss overarching goals and the ways in which organizations could work together for better public health. This plan was designed as a first step toward a more strategic and inclusive approach to improve communitywide disease prevention and access to health care. As such, this is a fluid document intended to shift as community data and feedback evolve.

Subsequent to the completion of the CHIP, a new Chief Health Officer, Marie Peoples, was hired to head the Coconino County Public Health Services District. Under her leadership, the CCPHSD was reorganized based on fiscal, customer service and administrative needs. The CCPHSD underwent further planning and came up with a set of goals that are aligned with the CHIP but with a few minor differences. The CCPHSD also refined its role in the larger public health system. These issues are discussed in the “Update and Next Steps” section.

## Method

In February 2013, 35 health care leaders in Flagstaff and 36 health care leaders in Page convened to:

- 1) Review data from the Coconino County Community Health Assessment (CHA)
- 2) Identify provider overlap, gaps in service coverage and community needs
- 3) Define the role of the Coconino County Public Health Services District (CCPHSD)

These 71 health care leaders represented non-profit organizations, government bodies, tribal representatives, community based organizations and health care providers. The following organizations participated in the planning:

- Flagstaff Medical Center
- North Country Health Care – Williams, Page, Flagstaff staff
- The Guidance Center
- Girls on the Run
- Williams Police Department
- First Things First
- Native Americans for Community Action
- Poore Free Medical Clinic
- Northern Arizona Public Employees Benefit Trust
- Mountain Heart Association
- Alliance for a Healthier Generation
- Sacred Peaks
- Tuba City Regional Health Care Center
- Northern Arizona Regional Behavioral Health Authority
- Salt River Project Power and Water
- Banner Health Clinic
- Zion's Way
- Page City Council
- Page Unified School District
- Coconino County Criminal Justice Coordinating Council- Page, AZ
- Pathways Recovery
- Encompass
- Rainbow Residential Treatment Center, Page, AZ
- Kaibeto District Behavioral Health System
- Kaibeto Chapter House
- Page Hospital
- Kaibeto Outpatient
- Page Head Start
- Canyonlands Health Care
- Tse Ya'ate School

PHSD staff members reviewed current health data to help guide the community discussions and areas of interest. The identified areas of concern from the epidemiological data and the community input (surveys and focus groups) in the Coconino County Community Health Assessment (CHA) were

- 1) Injury associated with alcohol consumption
- 2) Chronic illness including heart disease, diabetes, and obesity
- 3) Inability to access health care (financial, geographic, etc.)

The CHIP conference participants were organized into break-out groups based on the aforementioned identified major issues.

Each break-out group met during part of a full-day CHIP meeting. A facilitator trained in ToP (Technology of Participation - Registered Trademark<sup>1</sup>) methods helped the group to:

- Identify current system-wide activities.
- Identify systemic gaps in services and goals.
- Create strategies for addressing the gaps.

The results of both of the two CHIP sessions are included in this report.

## Assets, Gaps, and Strategies

### Injury Associated with Alcohol

Current situation: In 2010 unintentional injuries in Coconino County were the third leading cause of death, after cardiovascular disease and cancer, and the rate was almost twice as high as the rate for the U.S. Excessive drinking among adults in Coconino County (15%) is almost twice as high as the national benchmark (8%). Teen alcohol use was roughly 30% in 2010. Violent crime and alcohol abuse rates are higher in Coconino County than the nation. Finally, the highest percentages of arrests for “less serious” offenses in Coconino County were liquor law violations, followed by disorderly conduct, and then DUI cases<sup>2</sup>. Injury associated with alcohol, whether caused by a vehicle crash, domestic violence or an assault, deserves some much needed attention.

Systemic Gaps:

- 1) Few treatment centers and even fewer sober living support programs post-treatment
- 2) Lack of prevention activities for youth, starting at the grade and middle school levels

Strategic issue: There needs to be more prevention of alcohol abuse and more access to treatment centers for those diagnosed with alcoholism.

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<sup>1</sup> [http://partnersinparticipation.com/?page\\_id=48](http://partnersinparticipation.com/?page_id=48)

<sup>2</sup> Unless otherwise cited, all statistics comes from the Community Health Assessment, produced by the Coconino County Public Health Services District in 2013. Accessible at <http://coconino.az.gov/index.aspx?nid=222>

Key Result Areas: Providers would like to participate in semi-annual meetings to coordinate resources and activities. Community members will have access to a directory of services, which are kept updated and specific to the Northern (Page) and Southern (Flagstaff) Hubs of Coconino County.

Strategies:

For Page as the Northern Hub of Coconino County:

- I. **Goal:** To coordinate service providers
  - a. Communicate grant opportunities to stakeholders
    - i. Act as a coordinator for grants that may cross jurisdictional or organizational boundaries
    - ii. Send lists of available grants via email to providers
  - b. Participate in the existing Substance Abuse Task Force
    - i. Encourage collaboration and sharing of resources between providers
    - ii. Ensure stakeholder's efforts are not being doubled or do not conflict
- II. **Goal:** To promote awareness of prevention and treatment opportunities in the Page community
  - a. Create a list of all available services for alcohol prevention and treatment
    - i. List treatment programs by availability and cost
    - ii. Make the list available online and in print, distribute the printed list for those with no internet access
  - b. Distribute the printed list (paper copy) to health care facilities on the Navajo and Hopi Nations

For Flagstaff as the Southern Hub of Coconino County:

- I. **Goal:** To Coordinate service providers
  - a. Communicate grant opportunities to stakeholders
    - i. Act as a coordinator for grants that may cross jurisdictional or organizational boundaries
    - ii. Send lists of available grants via email to providers
  - b. Convene stakeholder meetings twice a year
    - i. Encourage collaboration and sharing of resources between providers
    - ii. Ensure stakeholders efforts are not being doubled or are conflicting
  - c. Monitor and evaluate data on alcohol-induced injury
    - i. Keep track of morbidity, mortality and alcohol consumption data
    - ii. Disseminate factual information at the stakeholder meeting
- II. **Goal:** To make the Flagstaff community aware of prevention and treatment opportunities
  - a. Create a list of all available services for alcohol prevention and treatment
    - i. List treatment programs by availability and cost
    - ii. Make the list available online and in print, distribute the printed list for those with no internet access

- b. Run youth and school based prevention programming
  - i. Educate elementary and middle school students on alcohol abuse
  - ii. Encourage youth groups to create their own programming on alcohol abuse

See Appendices A and B for the complete list of all assets, gaps and strategies mentioned by CHIP participants.

### Chronic Illness including Heart Disease, Diabetes, and Obesity

Current situation: Obesity is a prominent condition across the county and a key risk factor for several deadly chronic diseases. One of these diseases, diabetes, was once an illness of mostly older adults until the recent obesity epidemic took hold. Now, 21% of adults in Coconino County are obese. Obesity is a risk factor for half of the County's top ten leading causes of death -- cardiovascular disease, cancer, stroke, diabetes and some strains of influenza. In addition to genetics, a number of environmental factors contribute to the obesity problem, ranging from poor individual nutritional choices to lack of indoor fitness facilities to living in food deserts where healthy and low calorie foods aren't readily available. One in every eight low income individuals in the county lives in a food desert. Fast food restaurants are almost as common as sit-down establishments; 43% of all restaurants in the county serve fast food, which is typically high fat and high calorie. Finally, the disproportionate number of Native Americans with who die of diabetes is concerning<sup>3</sup>; Coconino County is home to part of the Navajo Nation, the Hopi Nation, and several smaller tribal sovereignties.

Systemic Gaps:

- 1) Uncoordinated systems of care
- 2) Unavailability of fresh fruits, vegetables, and safe, low-cost places to recreate
- 3) Lack of worksite wellness programs and school-centered physical activity

Strategic Issue: There needs to be more collaboration between nutrition and exercise professionals, more education and public outreach about weight loss and diet and more policy that addresses the structural causes of obesity.

Key Result Areas: Providers would like to participate in semi-annual meetings to coordinate resources and activities. Schools and businesses will participate in wellness programs or educational opportunities including school gardens.

Strategies:

For Page as the Northern Hub of Coconino County:

- I. **Goal:** To coordinate service providers
  - a. Convene stakeholder meetings three times a year
    - i. Encourage collaboration and sharing of resources between providers

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<sup>3</sup> Unless otherwise cited, all statistics comes from the Community Health Assessment, produced by the Coconino County Public Health Services District in 2013. Accessible at <http://coconino.az.gov/index.aspx?nid=222>

- ii. Ensure stakeholder's efforts are not being doubled or are conflicting
  - iii. Break into action groups for nutrition and physical education
  - iv. Include the Navajo and Hopi Nations as key partners
- II. **Goal:** To educate the community including youth
  - a. Create community gardens
  - b. Teach health education in schools
  - c. Hold health fairs at workplaces and community events

For Flagstaff as the Southern Hub of Coconino County:

- I. **Goal:** To coordinate service providers
  - a. Convene stakeholder meetings twice a year
    - i. Encourage collaboration and sharing of resources between providers
    - ii. Ensure stakeholders efforts are not being doubled or conflicting
  - b. Communicate grant opportunities to stakeholders
    - i. Act as a coordinator for grants that may cross jurisdictional or organizational boundaries
    - ii. Send lists of available grants via email to providers
  - c. Train service provider staff for increased efficacy
    - i. Strategic thinking
    - ii. Grant writing
    - iii. Policy
- II. **Goal:** To educate the community with a focus on youth
  - a. Create gardens for exercise and food systems education
    - i. Farms to Schools programming
    - ii. Community gardens
  - b. Support the creation of worksite wellness programs in local businesses
- III. **Goal:** To advocate for policies that prevent chronic illness
  - a. Promote policy preventing chronic illness at the Hermosa Vida Policy coalition
  - b. Advocate at a local and state level for chosen policies

See Appendices A and B for the complete list of all assets, gaps and strategies mentioned by CHIP participants.

## Access to Care

Current Situation: Though the ratio of primary care physicians to patients in the county is 1: 1,360, not all county residents can easily access primary care. Over 75% of Coconino County's adults and about 85% of children have health insurance<sup>4</sup> and those numbers are expected to increase when the

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Affordable Care Act (ACA) takes full effect in 2014. However, poverty and distance are two larger barriers to health care for many county residents. Flagstaff and Page enjoy modern medical facilities; more rural areas of the county do not. Transportation to and from population centers is lacking. While the Navajo Transit System does provide routes to some communities on the Navajo Nation, the route timing may not suffice for attending medical appointments<sup>5</sup>. The Arizona designation of “Medically Underserved Area” applies to all but the southeast quadrant of the county, with the northern half of the county being the most underserved.<sup>6</sup> Jurisdictional issues between the Native American nations and county providers may create gaps in continuity of care. Individuals with lower socio economic status cannot afford the gas or the time off work to attend appointments far from their home base, which can be as long as six-hour round trip.

Systemic Gaps:

- 1) Many uninsured or underinsured individuals
- 2) Lack of transportation to and from primary to tertiary care
- 3) No continuity of care
- 4) Poverty

Strategic Issue: Affordable transportation between major population centers needs to be enacted. In addition, medical care must be made affordable and available for rural and lower socio-economic status individuals.

Key result areas: The communities would like to see a public transportation route between Page and Tuba City for medical patients, a community health directory including free and low cost services, and a document guiding providers in the Affordable Care Act requirements.

Strategies:

For Page as the Northern Hub of Coconino County:

- I. **Goal:** To coordinate service providers
  - a. Communicate grant opportunities to stakeholders
    - i. Act as a coordinator for grants that may cross jurisdictional or organizational boundaries
    - ii. Send lists of available grants via email to providers
- II. **Goal:** To advocate for a medical services transportation system
  - a. Focus on a route from Page to Tuba City and back
  - b. Identify potential funding sources for regular medical transport vehicle
- III. **Goal:** To make the Page community aware of low-cost providers and screening opportunities

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<sup>5</sup> <http://www.navajotransit.com/index.php/routes.html>

<sup>6</sup> <http://www.azdhs.gov/hsd/designations/DownloadWindow/BaseMaps/AZMUA.pdf>

- a. Promote worksite wellness programs at schools and businesses
- b. Create a list of all available low and no cost services
  - i. List treatment programs by availability and cost
  - ii. Make the list available online and in print, distribute the printed list for those with no internet access

For Flagstaff as the Southern Hub of Coconino County:

- I. **Goal:** To coordinate service providers
  - a. Convene stakeholder meetings twice a year
    - i. Encourage collaboration and sharing of resources between providers
    - ii. Ensure stakeholders efforts are not being doubled or are conflicting
    - iii. Establish a mission and vision for the health care provider community as a whole
  - b. Communicate grant opportunities to stakeholders
    - i. Act as a coordinator for grants that may cross jurisdictional or organizational boundaries
    - ii. Send lists of available grants via email to providers
  - c. Hold meetings with CPHSD, FMC and North Country Health Care during the ACA transition
    - i. Discuss how the health exchanges will affect coverage
    - ii. Plan assistance for exchange users between the three systems
  - d. Train service provider staff for increased efficacy
    - i. Strategic thinking and logic models
    - ii. Epidemiology
    - iii. Data monitoring and evaluation
  - e. Lead a policy coalition to address relevant issues
- II. **Goal:** To advocate for a medical services transportation system
  - a. Support the expansion of the Northern Arizona Intergovernmental Public Transportation Authority (NAIPTA)
    - i. Focus on routes to and from outlying Flagstaff communities
    - ii. Identify potential funding sources for communities not in NAIPTA's tax base

See Appendices A and B for the complete list of all assets, gaps and strategies mentioned by CHIP participants.

## The Role of the CPHSD

Throughout the CHIP sessions, participants in both the Northern and Southern Hubs discussed the role they think the CPHSD should play in the Community Health Improvement Plan and in the greater public

health system in general. One group came up with the following statement which encapsulates many of the themes expressed by participants:

CCHD's role should be to coordinate collaboration efforts for policy change and education and be a resource center for access to services in order to improve and prevent CVD, obesity, and diabetes outcomes across county.

The themes that were mentioned the most frequently were the following:

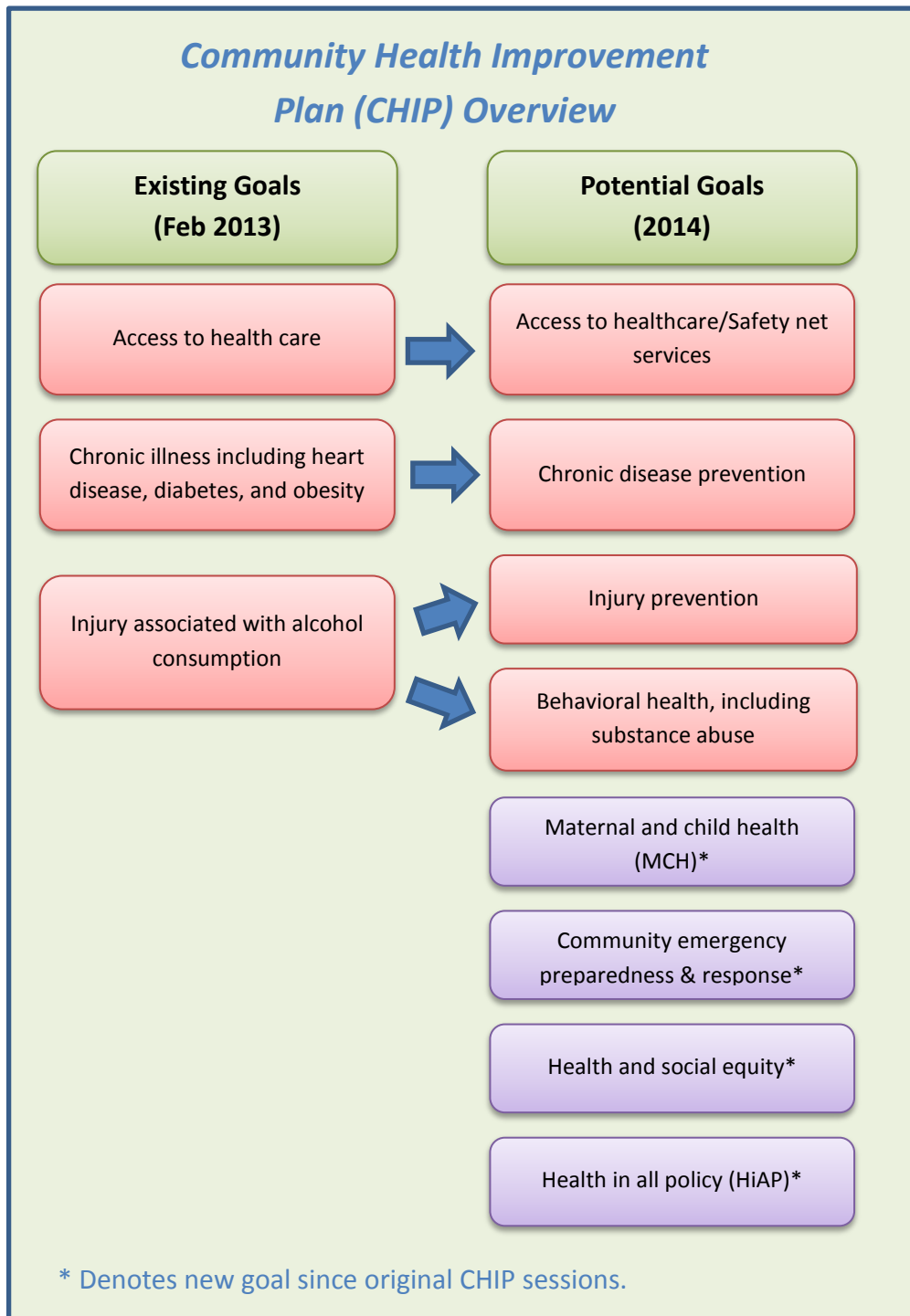
- *“Convene, collaborate, coordinate.”* The participants felt that the CCPHSD should coordinate community service providers and services, lead or attend task force meetings, provide “linkage” between providers, and “streamline” access to service.
- *Enact and enforce policies.* Participants saw the CCPHSD as the clear leader in policy change in Coconino County. Some also mentioned the District's role in enforcing policies, such as school nutrition policies and medical marijuana laws.
- *Educate.* Prevention, education and training for other providers were all suggested as possible activities for the CCPHSD to pursue. For example, the CCPHSD could train other organizations how to do wellness programs, train future health coaches, guide the schools on nutrition and physical activity efforts. Some also mentioned having a “campaign” focused on health issues, promoting health on cable television, and/or creating a virtual classroom for students.
- *Conduct research and evaluation.* Participants talked about the CCPHSD doing “data collection and analysis,” research and evaluation, health impact assessments, finding culturally appropriate models and models that have proved effective.
- *Find and/or secure funding sources.* Participants discussed the possibility of CCPHSD finding funding for the community or identifying grant opportunities. One example was finding more reimbursable services, particularly those that might be a part of the Affordable Care Act (ACA).

## Update and Next Steps

Subsequent to the facilitated CHIP sessions held in February 2013, a new Chief Health Officer, Marie Peoples, was hired to head the Coconino County Public Health Services District. Under her leadership, the CCPHSD was reorganized based on fiscal, customer service, and administrative needs. The CCPHSD underwent further strategic planning and defined its own goals and role (shown in Appendix D). In addition, CCPHSD staff reviewed and updated the CHA which provided further insights into health issues in the community. The most recent edition of the CHA can be found on the Coconino County website.

This section outlines the ways in which the CCPHSD roles and activities are aligned with the CHIP and provides suggestions for future additions and revisions to the document and the corresponding activities. The CCPHSD will convene the CHIP stakeholder group soon to solicit feedback on the additions and revisions.

1. Access to healthcare, chronic disease prevention, and injury prevention remain as goals shared by the CHIP and the CCPHSD.



These three goals were, and still are, supported by the epidemiological data and community concerns and thus they remain on the list of high priorities for CCPHSD and as goals for the community in the CHIP.

**2. The CHIP group may want to consider separating injury from alcohol.**

After further review of data and strategic planning, the CCPHSD divided the goal of “injury prevention due to alcohol” into two goals: injury prevention and, separately, substance abuse as a part of the larger behavioral health goal. There were several reasons for this. First, the data show that while there are some injuries that are alcohol-related, the majority are not. For example, bicycle-related injuries among children are almost exclusively non-alcohol-related. Second, many of the strategies suggested for alcohol-related injuries focus on larger substance abuse and behavioral health issues. To confine those strategies to injury prevention is limiting and may not engage the necessary stakeholders such as substance abuse recovery providers.

**3. The role of coordinator and facilitator suggested by the CHIP continues to be a role embraced by the CCPHSD.**

Two of the CCPHSD strategic goals are as follows: “Engage and build upon existing partnerships” and “Advocate for coordinated services.” While the CCPHSD may not be able to fulfill all of the roles CHIP participants suggested, working on coordination is still a focus.

**4. The CHIP group will need to revisit the activities assigned to CCPHSD and revise according to priorities and resources.**

Appendix C shows all of the activities or actions that were discussed as first steps in the Community Health Improvement Plan. The CHIP group will need to visit this plan and a) revise due dates (most of which passed while the CCPHSD was undergoing changes), b) review strategies to be sure they are still relevant, and c) confirm or reassign the responsible party. The last step is necessary because some positions listed no longer exist and because current resources may not allow the CCPHSD to take on all of the activities.

**5. The CHIP group may want to consider adding two topical goals to the plan.**

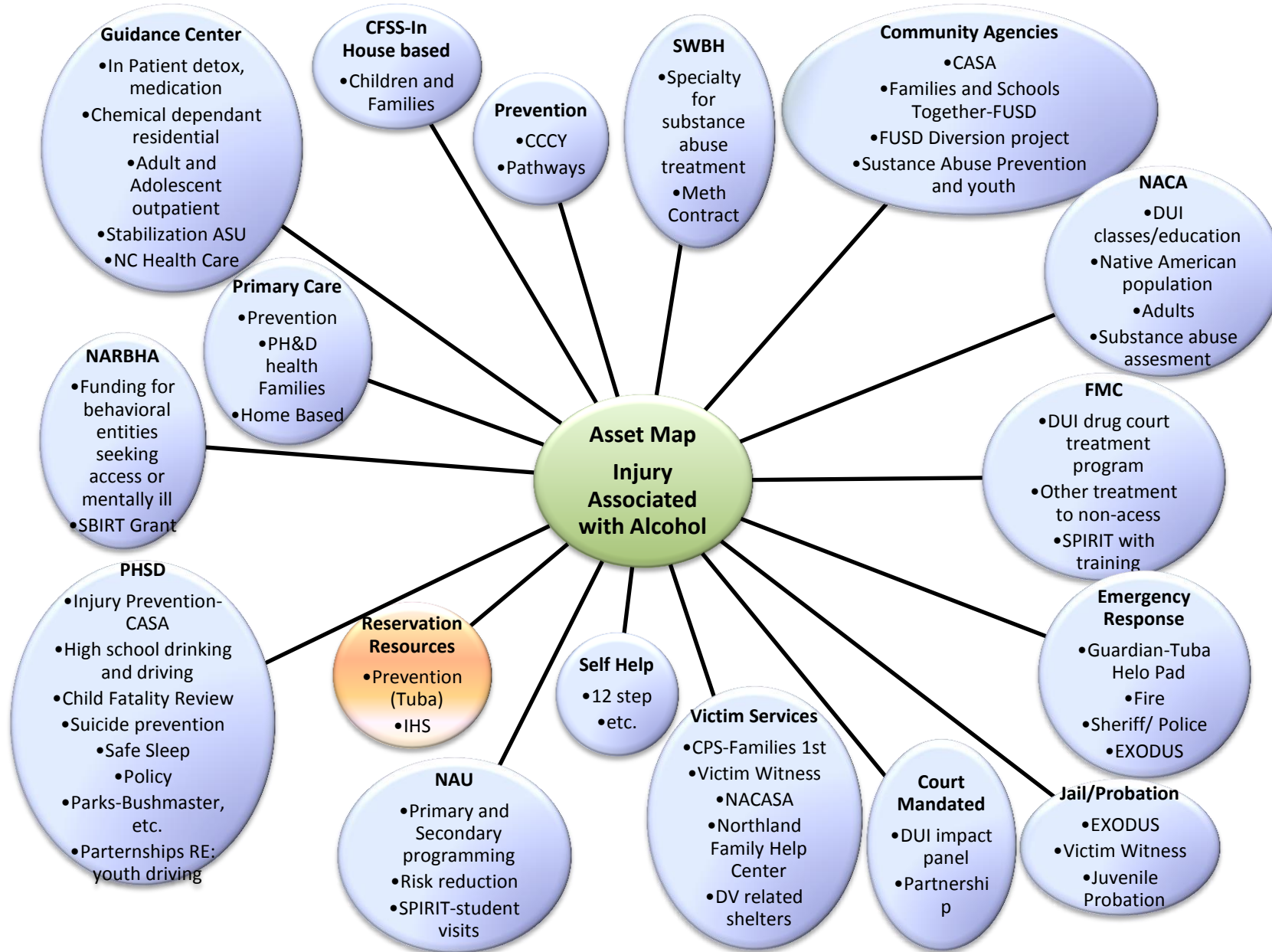
The CCPHSD has two new goals that were not presented to the CHIP, but were identified in the strategic planning process – maternal and child health (MCH) and emergency preparedness and response. While the CCPHSD could pursue these areas independent of the CHIP, a coordinated, communitywide effort would be much more effective in assuring public health.

**6. The CHIP group may want to consider adding some overarching goals that apply to all topics and issues.**

There are two overarching principles or goals that the CCPHSD believes are important for promoting public health. The first is Health in All Policies (HiAP) which is the idea that the community should strive to consider the health impacts of all policies that affect residents of the county. For example, how will a proposed park improvement or traffic change positively or negatively impact health? The second is social equity or the recognition that social determinants of health such as poverty or race/ethnicity have an impact upon the health of a community.

The Public Health Services District looks forward to meeting with partners, formalizing roles, and addressing additional service gaps. The strategies suggested by partners and stakeholders help guide the role of CCPHSD. The CCPHSD envisions signing Memoranda of Understanding with key partners in the months to come to define agency roles and responsibilities.

*Appendix A: CHIP Meeting with Providers February 4, 2013 Flagstaff (Southern Hub)*



**Gaps in service – Injury Associated with Alcohol (Southern Hub)**

- Flagstaff based
- Not enough treatment services
- Prevention of substance abuse
  - Ages 12-13 issue
  - Need for counselors in schools
  - Early on middle school
  - Fit Kids model-involves entire family
  - Families in School Together
- Post treatment services - “Sober Living” outside of environment
- Domestic violence - victim support beyond treatment-Sharon Manor Flagstaff based (waiting list)
- Transportation to services

**Solutions**

- Leupp - 45 miles away-no services
- Twin Arrows Community-Partnership opportunity
- Environment-outreach to vendors
  - no Sales 40 initiative
  - Influence policy/price of alcohol
- “Nothing else to do”- youth particularly outside of Flag
- Community Transportation Resource
  - Emergency Medical Technicians
  - Arizona State University
- Guidance Center Meeting
  - “Closing the Gap”
  - Chronic alcoholism and statistics

- Feb Fellowship
- Northern Arizona Regional Behavioral Health Authority grant
  - \$55K/5yrs for Community Coalitions RE: Environment and Prevention
    - Guidance Center staff to lead
- Prevention
  - Coordination of all resources particularly outside of Flagstaff
- Gap in Treatment
  - Long term options
  - Treatment for youth and family
- Need to look at laws-ability to hold patients 4 treatment
- Policy
  - Bar education, etc.
  - Motor vehicles-need for enforcement
  - Alcohol tax (state law)
- Community Coalitions outside of Flagstaff
  - Ex. Leupp
  - Other youth activities

**Public Health Services District’s role in injury related to alcohol**

- Coordination of community service providers
- Prevention (especially youth early on)
- Policy (state, legislative) - mobilizing community part
- Local ordinances
- Evaluation-planning, health impact assessments
- Enforcement around non-alcohol drug use (medical marijuana, prescription drug abuse)

<b>Southern Hub (Flagstaff), Injury Associated with Alcohol- What specific actions/strategies can the CPHSD use to impact this issue?</b>						
<b>Policy and Advocacy</b>	<b>Educate and support effective enforcement</b>	<b>Convene, Collaborate, Coordinate</b>	<b>Identify and support fundraising</b>	<b>Data collection and Analysis</b>	<b>Educate and mobilize the community</b>	<b>Youth-Based prevention</b>
Involve policy makers in meetings like this	More awareness training for law enforcement, Courts, etc. for more long term success	Organize providers -Collaborate -Focus	Help identify/write grants/other funding	Monitor trends related to alcohol/substance use, morbidity and mortality, and raising awareness	Educate community members on issues	Education and prevention at the school based level
Lobby State legislature to adopt statute for 72° hold	Encourage/enable law enforcement related to alcohol	Create and electronic directory of services on alcohol related injury	Partner with Twin Arrows Casino to address alcohol problems in the community	Collect, disseminate, and evaluate community specific data	Educate community about political issues	More prevention/school and families counseling
Conduct a policy scan to identify policy opportunities and mobilize community response	Enforce medical marijuana and any prescription drug efforts	Facilitate consistent conversation between existing efforts	Obtain grant funds to provide long term treatment	Collecting injury data from community health clinics to determine data by community	Mobilize the community to demand ordinances and laws to lower injuries RE: alcohol	Focus on prevention in elementary education
Mobilize efforts to work on policy related to alcohol tax increase and motor vehicle efforts among others		Coordinate county-wide prevention/treatment services	Work with new casino to obtain support/funding	Evaluate ongoing efforts to address alcohol/substance use in the county and determine gaps	Individual community engagement and empowerment (youth build programs) (resource lists)	More prevention programs for youth
Develop alcohol tax initiative		Easier accessibility to services in outlying areas	Work to make Screening, Brief Intervention, and Referral to Treatment (SBIRT) efforts reimbursable for Emergency Room (ER)/1° facilities so that it continues after grant	Identify ways /position the county to focus prevention efforts on newly emerging substances (prescription drugs, spice, designer drugs)	Establish regular meetings with bar owners within the community to promote training and awareness to the problem	
Pursue and alcohol tax to fund treatment and transportation		Group meetings with stake holders and policy makers/legislators	Identify funding to prevent alcohol related injury	Conduct health and impact assessments to determine consequences related to alcohol, substance use	Develop coalition of community members	
Work on public ordinance RE: Alcohol				Evaluate effectiveness of existing services	Hold community meetings	
Advocate for transportation (Williams, Leupp, Page)					Conduct targeted media campaign to raise norms (impacts of issue)	

## Chronic Disease

### Gaps-Obesity, Diabetes, HD (Southern Hub)

- Transportation to services
- Community volunteers or people to go into homes
  - E.g. Verde Valley Caregivers
- Access to health foods and how to use
- Policies to support healthy eating/foods
- Health coaches who are up on latest, help you access
- More worksite wellness
- More health insurance support for prevention
- More community health workers (community health workers)
- More community health worker training
- HD awareness campaign including coordination, etc.
- Sleep medicine awareness camp
  - Link with sleep apnea and diabetes
  - Link with insulin
- Standardized training program for medical assistants
- Safe, free places for activity
- Easy way to find services, which are free
- More services for free
- Coordination of network
- Activities on nutrition an activity integrated into school
- Expand Hermosa Vida (in Sunnyside neighborhood) to other areas
- Improved access to inpatient and outpatient behavioral health services
- Expansion of Medicaid to 133% of poverty level

### **Coconino County Public Health Services District's Role in Chronic Disease**

- Bringing provider community together-linkage
- Policy change, represent whole county
- Train other organizations how to do worksite wellness programs
- Training for future health coaches, medical assistants-perhaps help low income folks get jobs
- CCPHSD could support training program at Navajo Nation
- Expand state, Navajo programs to Coconino County
- Collaboration
  - Community Linkages
    - Connecting resources to each other
    - No duplication or overlap-streamline
- Policy change
- Education
- Campaign
- One-stop call from public

CCPHSD role should be to coordinate collaboration efforts for policy change and education and be a resource center for access to services in order to improve and prevent CVD, obesity, and diabetes outcomes across county.

### Notes from Chronic Disease Mapping Resources Discussion

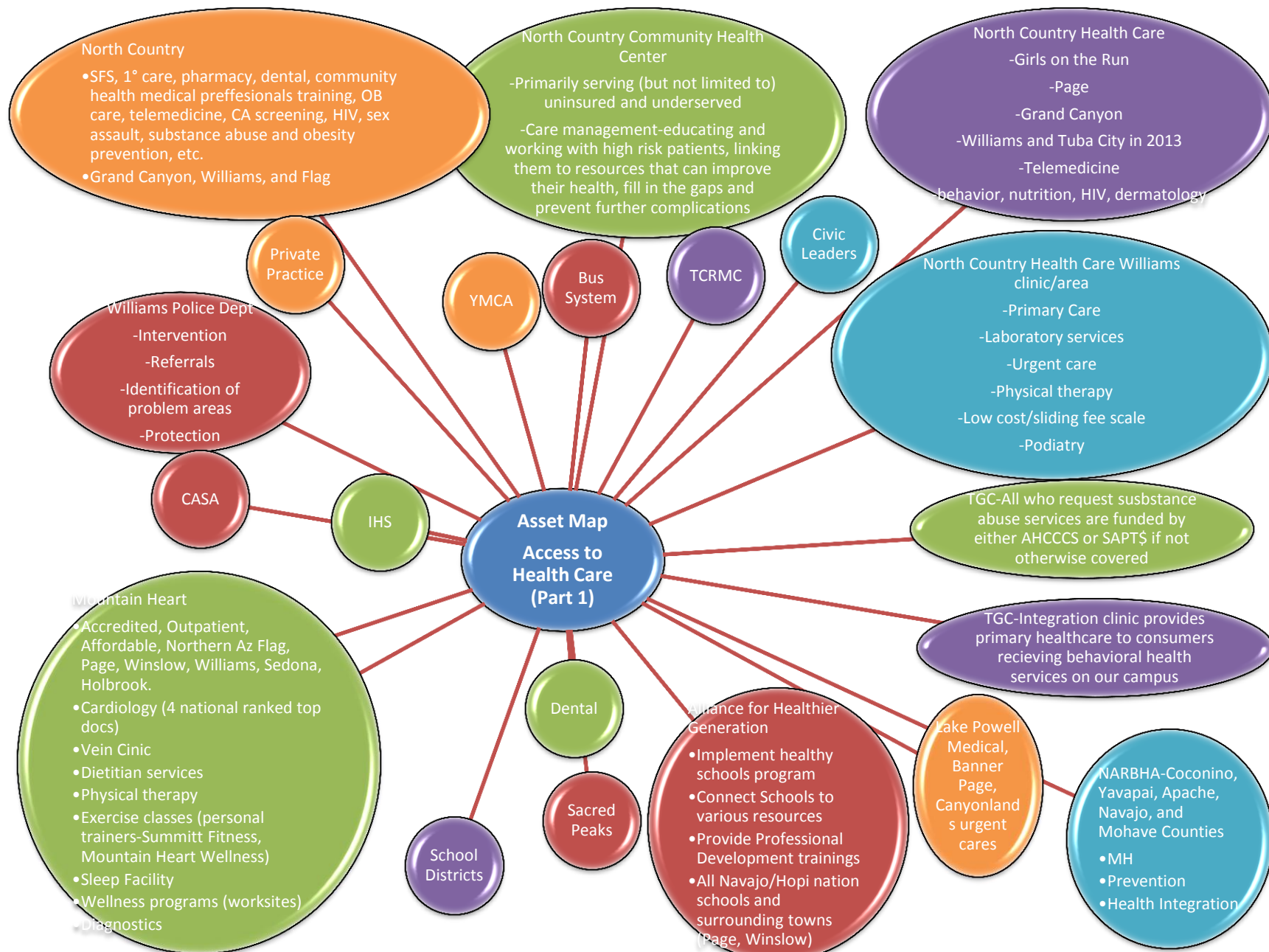
- Chronic Disease (Services Intervention)
  - CCPHSD (Marty)
    - Tobacco/chronic disease
    - Quit smoking
    - Healthy living class
    - Caregivers
  - North Country HealthCare (NCHC) - Williams (Nell)
    - Diabetic Nutrition
    - Refer kids to FMC
    - Refer kids to own clinic
  - Care Coordination (Lisa)
    - Williams/NCHC agencies
    - Want to reach out to discharged, meds, etc.
    - Diabetic education
    - Outpatient side too
  - Flagstaff Medical Center/Northern Arizona Health Care (Rich)
    - 6 clinics
    - Referrals
    - Kids with high BMI
- Kids at school inc. activity
- Health education
- North Country (Ashley)
  - Care management for patients from high risk-A1C's over 9, cardiac episode
  - Depression patients
  - Girls on the Run-conf. joyful healthy, 12 week curriculum, body image
  - Sunnyside Hermosa Vida-elementary school physical activity, produce, comm. healthy lifestyle.
  - Mountain Heart-wellness, dietician, nutrition, transition
- NACA (Native Americans for Community Action)
  - Substance-kids
  - Depression screening, HIV, activity for kids
  - Wellness Center-cardio, obesity
- Diabetes Together (Flagstaff Medical Center, but community grant)-Christine
  - All organizations participate
  - Health initiative-goals
    - Northern Arizona Resources Guide
    - Diabetes screening

- Food survey in Sunnyside-dialogue with HCP's
  - Medical Assistants training
- Tuba City (Holly)
  - Healthy Living center-exercise, nutrition, etc. for patients
  - Telemedicine
  - Primary care
  - Active community exercise
  - Native Americans only
- Northern Arizona Trust
  - Employee only wellness-county, community colleges, other gov't and dependents
  - Coordinate resources
  - Classes on yoga, nutrition
  - 10 locations
  - 1 on1 nutrition, cooking, weight loss
- YMCA
  - Diabetes support group, prevention, maintenance
  - Small charge
- Flagstaff Community Health Action Network (CHAN)
  - Advocacy, education, network, blog
- Dental Clinics
  - Low Cost
  - CCHD
  - Northern Arizona University
  - Cameron
  - 1<sup>st</sup> things 1<sup>st</sup>- dental
  - Kids through age 5- all county
  - Scale sheets
- CPHSD
  - Physical activity, 1000 health challenge
- Northern Arizona Regional Behavioral Health Authority, North Country, A3
  - Healthy Living
- Flagstaff Medical Center Telemedicine
  - Accepts referrals from hospital or community
  - Send patients home with equipment
  - Nurse follow-up
- Northern Arizona University-health psych
  - Master's students-healthy living
- CCHD

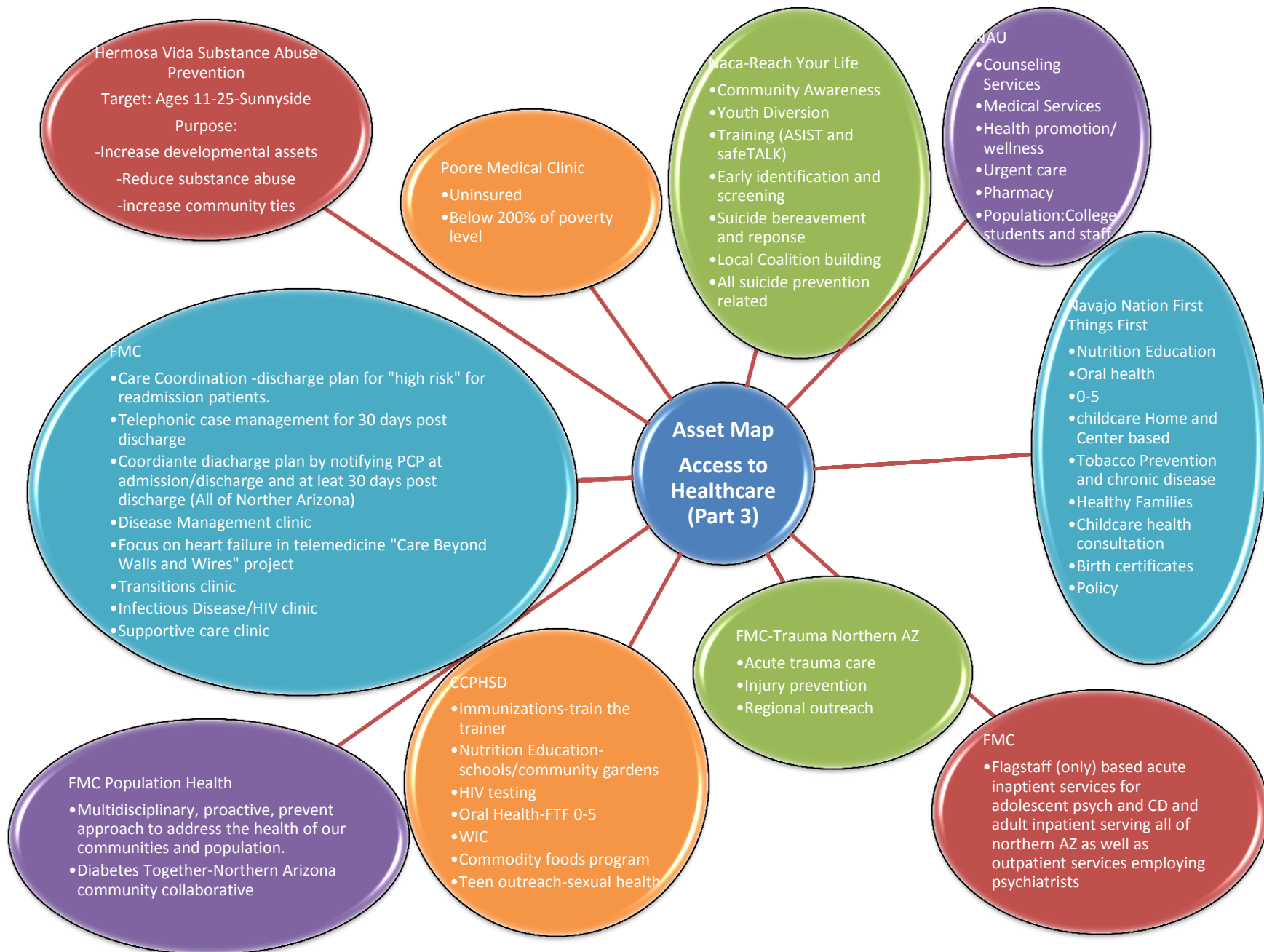
- Women, Infants and Children (CCPHSD)
  - Breastfeeding
  - Nutritional/activity counseling
  - Community foods-kids
- AZ Nutrition Network
  - Low income schools-nutrition
  - Seniors
  - Walking
  - School buses
  - Policy change in school
  - HIV/Oral
  - CDC
- North Country
  - Retinal screening
- Intensive management classes-eng/span
- 1 on1 nutrition
- Support groups
- Diabetes day-3 appointments with educators
- Guidance Center
  - Behavioral health services
  - Native Americans for Community Action-out patient
- Alliance for Healthier Generation
  - Connect resources to schools
  - Provide professional development training in areas of physical activity and nutrition
  - Work with schools on-line and on-site
    - On-site-Navajo Nation and surrounding schools along reservation

<b>Southern Hub (Flagstaff), Chronic Disease - Strategies</b>				
<b>Assessment</b>	<b>Leadership</b>	<b>Policy</b>	<b>Funding</b>	<b>Training</b>
Assets map of county resources available to coordinating resources	Bi-yearly stakeholder meeting (1/2 day)	Create policy for price of produce	Apply for funding for home health visitors/promoters and community health workers	Community based: train/build home volunteers and community health workers
Current transportation	Combine meetings-Flagstaff and diabetes together	Advocate for local, state, and federal policies that impact health and social services	Write FCF grant to fund coordination efforts	Coordinate regional trainings for health promotions to HR wellness coordinator and administration
Assess need for med and how it leads to re-entry in hospital	Assure that healthful foods (e.g. Bountiful Baskets) are accessible	CCPHSD should be the lead on a health policy coalition	Connect organizations working on similar grants	Coordinate regional trainings on “how to’s” for policy for grants or worksite/schools
	Collaboration with health providers for linking community health resources	Fast food policy-# of site per capita	Grant funding for medications and supplies	Train-the-Trainer: prevention county wide programs

	Collaborate worksite wellness			
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Gaps in Service – Southern Hub (Flagstaff)

- Uninsured/underinsured
- One primary Level One service provider, only in Flagstaff (transportation, access)
- Access to fresh food and healthier options
- Health information exchange to track care across a continuum-systems don't communicate
- Language-educations, service, delivery

Public Health Services District's Role

- Transport-Assess what is available
  - ID other resources-best use of current resources
- Affordable Care Act
  - Education
  - What?
  - When?
- Medicare-Education about the benefit
- Access to healthy food
- Health equity-same health outcomes
- Socio-Economic status? Jobs? +Insurance
- Streamline access to services

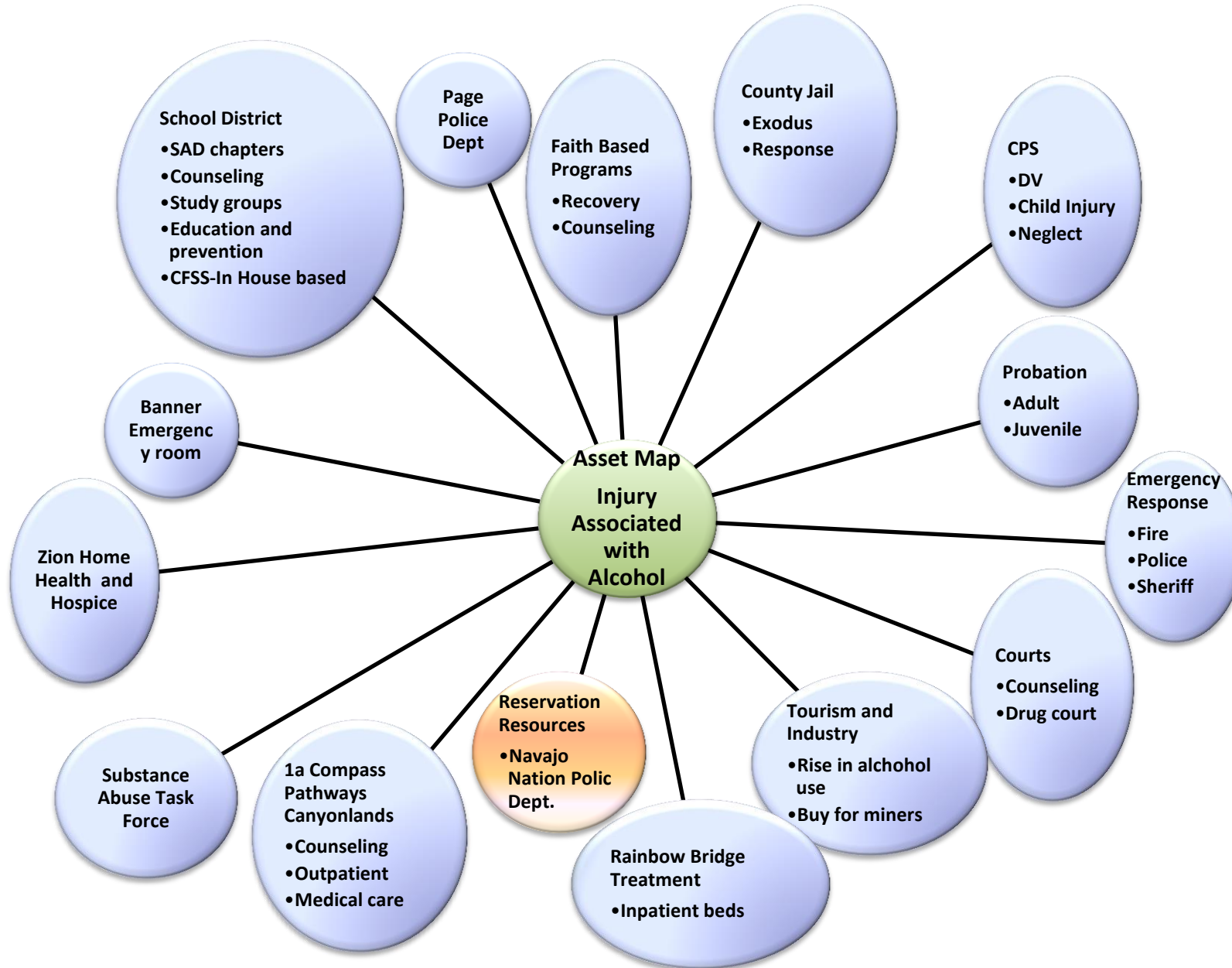
<b>Southern Hub (Flagstaff), Access to Care - Strategies</b>					
<b>ACA Educate and Engage</b>	<b>Coordinate Communication</b>	<b>Identify and collaboratively address barriers</b>	<b>Research and Evaluate</b>	<b>Training for CHW and prevention (explore expanding)</b>	<b>Healthy Foods (policy, education, coordination)</b>
Provide education/information about ACA and Medicare coverage	Establish a clear message/goal (Mission, vision, etc.)	Work with ADOT to increase/map bus routes to healthcare services	Gather info to help assess what is working	Community health worker training and workforce development a la CDSMP (Prevention)	Play a leadership role in food security/access to healthy food
Public Forums in Coconino County communities on <ul style="list-style-type: none"> <li>• Affordable Care Act</li> <li>• Medicare Benefits</li> <li>• Available resources within the</li> </ul>	Help us understand county and state level money available for services	Public Transport (Light Rail) Bussing from outlying areas	Data drill downs		Help fund/sponsor community gardens

community					
Medicare/ACA information day	Centralize communication	Page <->Flagstaff bus/transportation (like Tuba City)			Extend WIC to older children and increase max income guidelines
Educate the public RE: Affordable Care Act i.e, “ACA for Dummies”	Help citizens to navigate health exchange websites	More Mobile Health clinics			Job creation/access to healthy foods through gardening and farmers markets in rural areas
Create new jobs where trained people help others navigate Medicare and ACA	Educate providers and public <ul style="list-style-type: none"> <li>• Services, needs</li> <li>• Political issues</li> <li>• Plans</li> </ul>	AHCCCS mobile enrollment bus			Seek to assist people with securing health insurance coverage/SNAP
Information/Training forum regarding affordable healthcare/Medicare/etc.	Give incentives for healthy lifestyles	Engage in care transitions (hospital ->1° care) for increasing health outcomes			
	Establish a clearing house to guide people thru the waters. Manned by a person	Stream lining patient intake process			
	Clear internet site for Q&A for health services and access	Taking lead on policy change and develop coalition			
	Taking lead on becoming the coordination source for the county	Work to address health inequities and upstream social determinants of health (nutrition, education, jobs, SES)			

**Next Steps****To Send out**

1. Unintentional injury Definition
2. DUI %
3. Participants list
4. Participants roles/activities

## Appendix B: CHIP Meeting with Providers February 7, 2013 Page (Northern Hub)



**Gaps in service – Injury Associated with Alcohol**

- Emergency room and Criminal Justice only source of services, no access to health care for the working poor
- Mentally ill population without access to medications
- Transportation issues associated with alcohol, prohibit access to services or jobs, etc
- Youth needs for transportation to jobs and services leads to hopelessness and alcohol related issues
- Jurisdictional issues- school district, emergency response, access to services, enforcement
- Food deserts, low income and isolation in rural areas all contribute to break down with family and community
- Youth on reservations- who? Responds?
- Lack of ability to coordinate efforts, feedback needed for better service delivery
- Inconsistent service providers, agency stability
- Funding for counseling assistance
- Agency ethics
- Counseling services, Title 19, Northern Arizona Regional Behavioral Health Authority funding resources have different requirements
- School permission forms, adults not willing to let kids go to counseling, challenging to get permission from adults for intake for minors
- Grant writing for training, and funds for free services
- Lack of staff resources to take clients to Flagstaff for services
- Lack of funds for afterschool and recreation activities such as pools, parks, recreation classes
- Funding tied to population on Navajo Nation, does not consider geographical distances
- School liability issues- problems with providing services such as martial arts programming
- Integration between alcohol and mental health issues is not happening, goal, not here yet on Navajo Nation
- State doesn't support long term in patient treatment
- Public intoxication law, state level prohibits local laws
- Some issues tied to homeless community- gap of services for this community including helping them find employment
- Steadiness of income not possible because Page area is prominently seasonal employment and seasonal workers don't qualify for unemployment benefits or Arizona Health Care Cost Containment System (AHCCCS)
- A felony record keeps former criminals from access to services
- State Laws are strict about what qualifies as a felony- 3 DUI, shop lifting, DV, child endangerment are all felonies
- Businesses selling alcohol could be worked with, Utah controls the sale of alcohol more effectively
- Minors are able to purchase alcohol
- Prevention Education, huge disconnect
- Youth returns home to an environment that doesn't reinforce what they learn at school
- Prevention should also be outreach to families and include protective factors
- Assessment at community level would help Page inform and educate families about what the problems are
- Kids grow up with norm of alcohol abuse

- Expectations that services will be only in Page, lack of services outside
- Services need to be culturally appropriate and reflect diversity
- Most evidence based studies are based on white middle class- Northern Arizona Regional Behavioral Health Authority matrix model as example
- Change from school to home
- Page summer culture- white European tourist
- Systems approach including cultural diversity
- No services while waiting to get into treatment for alcoholism

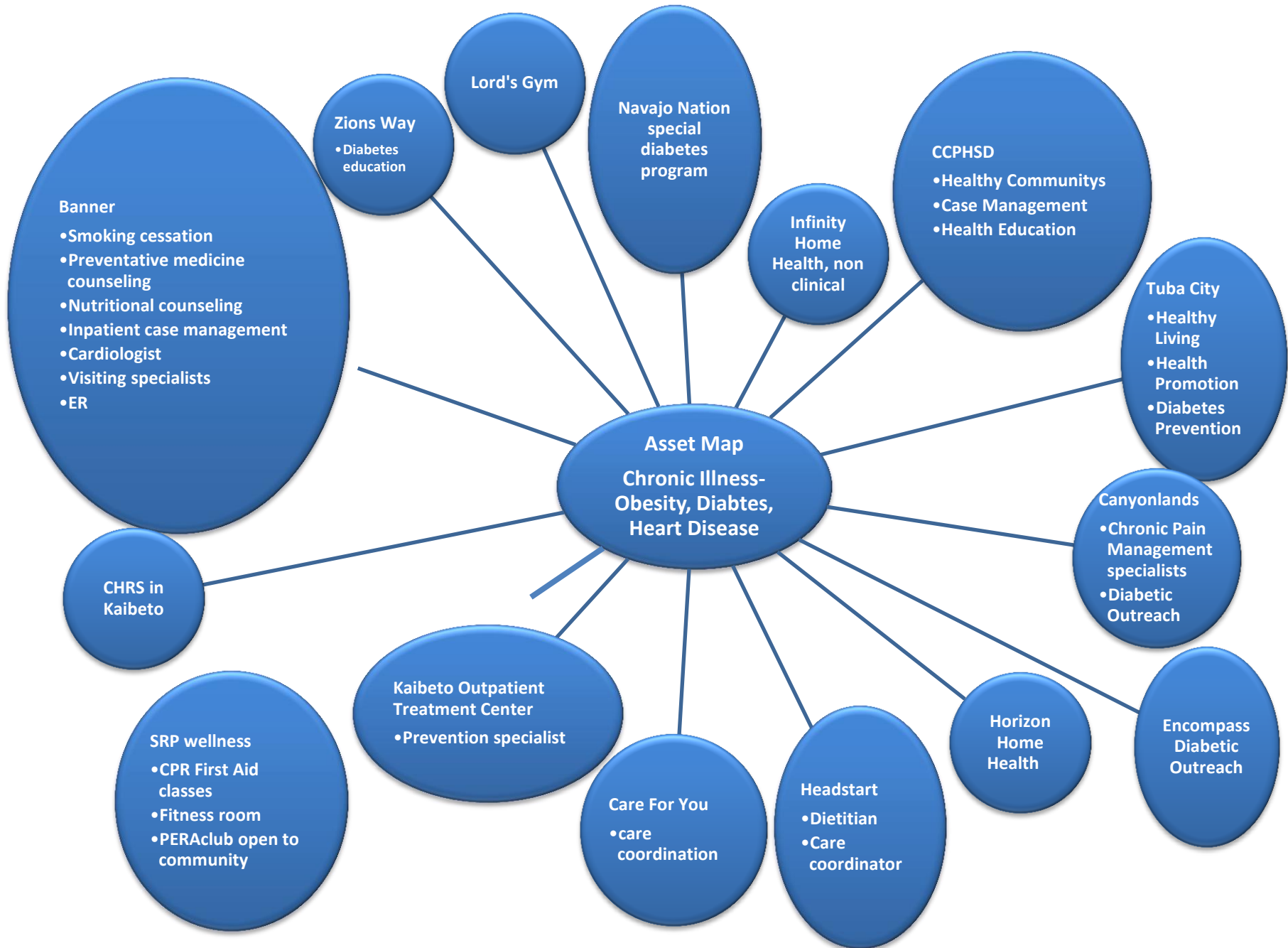
#### Public Health Services District's role in injury related to alcohol

- As a facilitator who can give common definitions of interventions, without agenda and unbiased
- Facilitating referrals for mental health, as a continuum of care goal
- Prevention programs that are community based so that everyone is involved- use the SAMSA model
- Attend Task Force meetings as a member

- As an outside agency who can bring in entire system and data on success or doing it differently
- Improve efficiency in current activity- case management for serial inebriates: mandate it and make it more effective
- Focus on education and outreach in homes and schools, family focus and youth interventions at 4<sup>th</sup> and 5<sup>th</sup> grade
- Mediator between different points of view, families
- Coordinator- provide consistent research, assessments, models, gather data and provide info
- Bring together service providers, help all buy into the system and work together. Integration
- Communicator, make sure service providers aren't duplicating services and create flow charts of who does what
- Create a directory of resources for the Page area and have it be visible. Who does what?

Injury Associated with Alcohol – Northern Hub (Page) - What specific actions/strategies can the CPHSD use to impact this issue?					
Participate and support the local Task Force	Countywide Communication and Sharing	Actively Coordinate and Broker Collaboration	Coordinate and Communicate Grant Opportunities	Document and identify culturally appropriate model	Design Collaborative Prevention Program
Go to meetings	Provide a website with available resources, contact information, and programmatic strategies and methods	Coordinating a quarterly meeting with community agencies	Establishment of funding for services	How do you protect prevention groups within a dysfunctional community, family or individual	Collaboration with local agencies in prevention programs
Focus efforts on prevention	Printed community resource directory that is up to date	Easy transition of services	Advocate that all service agencies provide pro bono services for uninsured	Integrated culturally appropriate E.B.P. Prevention and treatment	All ages, all cultures, educational outreach prevention activities
Public relations campaign for liquor	Information management, coordinate and manage	Get all the local players on the same page	90% client care, 10% administrative costs	Locate and identify culturally appropriate best	Provide community wide prevention strategy

distributors- enforce it	community partnerships			practices for alcohol abuse and dependency	
	Communicate CPHSD services to community stakeholders	Mediation to improve cross cultural relationships	Advocate and monetary support for the homeless, for example a shelter	Educate families, population specific	Provide home based psycho-education for families with alcohol
	Information and local data sharing, Page based	Help avoid workforce burnout by professional self care			
	Informational output for resources	Annual training sessions on cultural competency and diversity			
	Establish the network of services available	Build individual's intra-personal skills			
		Locate and involve spokespeople from the Native American communities to get involved in the community			



**Gaps-Obesity, Diabetes, HD – Northern Hub (Page)**

- Transportation to services- Native Americans living in Page can't get back to Indian Health Service facility
- Increase reimbursable services available, homebound are not eligible for home services
- Health empowerment, depression, provider role
- Behavioral interventions with communicable disease management, training for functional assessment and brief intervention
- Head Start sees BMI rising, but doesn't have resources to respond
- Acute focus because hierarchy of needs
- Technology and infrastructure to stay connected with doctor
- Non-insured sliding fees not possible, financial cycle
- Navajo Nation schools- new policy for referrals as 2000 students are obese
- Monitoring body mass index (BMI) but not following up
- How do we hold individuals accountable for their own health
- Health information exchanges, rise in coordination, individual providers communicate differently (via text rather than call) communicate better, more efficiently
- Canyonlands is losing patients 5-11 years old, health disparity
- Families with many children focus medical resources on youngest kids
- Provide behavioral support at community, environment, and family level
- Patients and parents don't participate in free support services
- No stores available
- Access to fresh food an issue

- Parents don't have time because they commute to work, no more cooking
- Fruits and veggies are expensive
- PE and food served in cafeteria- school policy lacking
- We're too spread out so it's difficult to build a community
- Activities for kids, changing attitudes, right brained ideas from left brained thinkers doesn't work
- Safe places to play
- Scared of dogs
- PUSD kids are bused up to an hour, don't live in the community
- More communication needed with Tuba
- Health care systems aren't coordinated- I.H.S. AHCCCS Canyonlands prevention

**Coconino County Public Health Services District's Role in Chronic Disease**

- Food in schools- educate schools so the school lunches are feeding kids well. Guide schools in prevention and practice of diabetes control
- Technology and infrastructure regarding healthy exchanges- something must be available to increase communication across agencies with HIPAA, centralized database, IM texting system, website featuring calendar with services, planning coordination
- Health Empowerment- change mindset, behavior change, knowing what's available
- More reimbursable services- incentives to participate in education

- How do we coordinate services? Available services?  
Calendars?
- Transportation- busing vouchers, more far reaching services, roads, walk able, bikeable, road quality
- Policy- food, diabetes prevention
- Diabetes prevention education everywhere- the issue is more prevalent, its relationship with mental health, schools and enforcement, related stressors
- Dissemination of web based that is low tech- NOT web based. It should be DVD or even VHS
- Exercise friendly environment
- Care coordination with public health nursing, aid all agencies in care coordination
- Farms to Schools- United States Department of Agriculture program
- School Wellness policies must be enforced

<b>Northern Hub (Page) - Chronic Illness – What specific strategies can CCPHSD use?</b>						
<b>Conceptualize Individual Care Coordination</b>	<b>Guidance and resources to build a Healthy Environment</b>	<b>Funding transportation</b>	<b>Develop wellness council to organize collaborative efforts</b>	<b>Marketing</b>	<b>Develop, implement and monitor policy</b>	<b>Increase and maintain community education</b>
Centralized data base	Eliminate illegal solid waste dumping	Free for underserved populations	3 meetings a year to share program information, Lead committees for specific issues, such as nutrition	Use media like radio and the Navajo Times locally to communicate	Food policy change	Educate public how to read food labels
Public Health nurse concept to coordinate care	Exercise friendly community- walking trails, skate parks, bike lanes	Increase funding for medical related transport	Conduct a training on networking	Disseminate community calendar for resources and exchange of services	Tax exemption on stores selling healthy food	Increased health education in schools
	Free spay and neuter mobile clinic		ADHS sponsored website centralizes care and services coordination		Enforcement of LWP at schools- incentive based	Health Fairs
			Coordinate this program with programs that are already successful such as the Jaime Oliver Food Revolution		School based county initiative for body mass index screening and referrals	Community gardens
			Be sure to involve the Navajo Nation Health Department		Advocate on behalf of schools for the Farm to	Virtual classrooms at Chapters

					School program	linked to the city of Page
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## Access to Healthcare – Northern Hub (Page)

### Barriers to Health Care

- Juvenile parental consent
- Under and un-insured
- Transportation- no transit system, no money for cars, certain providers limit availability to physicians and medications
- Indian Health Service doesn't cover visiting specialists, Arizona Health Care Cost Containment System (AHCCCS) may not either
- Language communication
- Better cooperation with Navajo Nation Tribes, examples is transit to Flagstaff, not to Page
- Food, access to healthy food, forced to drive long distances to eat healthy
- No recreation or wellness centers
- Lack of registered or certified school nurses
- Lack of money, finances
- Jurisdictional or intergovernmental relations
- Costs of treatment and mediation are too high for limited resources
- Education, emergency room shouldn't be the default. Go to doctor's office for basic problems
- Lack of understanding of health consequences
- Lack of understanding of completeness of existing services
- Length of time to get medications filled- ER is seen as one stop shop so they don't have to wait for meds at the pharmacy or to get a doc appointment
- Indian Health Service seen as a quality facility but not everything is offered there- educate on what they can do there
- No Indian Health Service facilities in Page so you pay the cost to travel
- Sliding scales don't go to zero
- Lack of agreements with other facilities to provide covered Indian Health Service services

- School district does not have a specific philosophy about what role to play with community partners
- Lack expertise to develop K-12 best practices at school district
- Individuals stay sick before they get care, lack of onsite wellness programs

#### **Addressing barriers**

- Faith-based women's shelter
- Community rural based school health centers initiative goal for school based clinics
- Healthy food, land use planning, pilot projects at Chapter level
- Local Governance Act- local Chapters can develop their own economic development plans and projects, qualified administrators at Chapter level
- Tuba City Schools need body mass index surveillance to address childhood obesity and prevention. Referral system for treatment. 60% of students are obese. Lifestyle changes and treatment
- Dine community Advocacy Alliance- Health Promotion- Educate legislators- certain % tax revenue for health promotion- tax on soda etc
- Compass e-letter goes to 171 businesses and churches. Expand it to chapter houses and put it in native languages. Focus articles on health consequences like substance abuse
- City of Page juveniles transported to Flagstaff, instead a diversion program where they take classes and do community service
- Coordinate juvenile programming for those without insurance- drug and alcohol programming for life skills, classes, community services
- Alternative High School- pilot to address challenges with kids raising siblings, technology etc.

#### **PHSD Role**

- Teach health principles of success
- More promotion of solutions on cable TV, a website- one place to find resources
- Virtual classrooms for students
- Community clinics with sliding fee scale, walk in services (note- Canyonlands Urgent Care does this)
- Mobile dental clinic and other mobile services like immunizations
- Tuba City Regional Health and Veterans have mobile clinics, but make people aware of their services
- Page virtual clinic for veterans
- Being an active advocate for reimbursable expenses with insurance. SDPI grant to fund free services, continue this money
- Assist with securing resources for grant writing etc.
- Involvement with substance abuse task force and put that info on website

<b>Access to Care – Northern Hub (Page)</b> What specific actions/strategies can the use to impact this issue?				
<b>Coordinate and encourage collaboration</b>	<b>Web-based community health directory</b>	<b>Advocacy for Transportation</b>	<b>Educate, Collaborate and support wellness initiatives</b>	<b>Consult and Coordinate information on grants</b>
Market local services including advertisements on bill boards	List community events and activities for increased participation	Promote a transit system between Page and Tuba City	Use schools as health centers	
Act as a liaison between existing health services and programs	Keep the current website updated with latest resources and information	Create a bus voucher system for people who are going to the doctor	School nurses as educators and primary health care providers	
Offer similar services in Page that are offered in Flagstaff	List health resources available to the community		Onsite employee health care at schools and work places	
Care coordination on an agency level	Use local media to promote current services available		Encourage healthy competition among stakeholders through employee wellness programs	
Participate in the Substance Abuse Task Force on the 2 <sup>nd</sup> Monday	Link the website to all partner orgs and on Chapter Houses- website interlinks		Train trainers, continuing education for teachers, counselors, and doctors	
Increase public health service health promotions in each community served by ADHS	Memorandum of Agreement with tribal governments for info sharing and programming		Public relations campaign for liquor distributors- must be enforced!	
Identifying the direct services available to serve the need at the moment	Identify and develop consistent accessibility to health care			
Encourage community involvement	Educate on the HIPPA confidentiality agreement between a patient and the provider, dispel and reassure those who have had a bad experience			

**To Send out**

5. Unintentional injury Definition
6. DUI %
7. Participants list
8. Participants roles/activities

## Appendix C: Strategies with Responsible Parties and Dates

### Injury Associated with Alcohol - Plan

Hub	Strategy	Associated policy change	Title of responsible party*	Early Milestones	Date*
Northern and Southern	Communicate Grant opportunities to stakeholders	None	Grant Writer	Establish an email list of stakeholders by scope of work	Start date: July 1 <sup>st</sup> , 2013
Northern	Participate in existing Substance Abuse Task Force	None	Senior Manager in Page, AZ	Attend meetings regularly	Start date: Next scheduled meeting
Northern and Southern	Create a list of all available services for alcohol prevention and treatment	None	Administration Specialist in Flagstaff	Contact all possible providers	August 2013
Northern	Distribute the paper copies to health care facilities on the Navajo and Hopi Nations	None	Senior Manager in Page and Tuba City CCHSD staff	Provide 50% of Navajo and Hopi Nation providers a copy	January 2014
Southern	Convene stakeholder meetings twice a year	None	Chief Health Officer	Schedule initial meeting for August 2013 and begin planning process	May 2013
Southern	Monitor and evaluate data on alcohol-induced injury	None	Epidemiologist	Complete annual review of data	January 2014
Southern	Run youth and school based prevention programming	Establishing enabling policies at individual schools or districts	Injury Prevention Specialists	Serve 20% of county schools, making a greater effort to reach schools outside the Flagstaff area	2014-2015 school year

\*Responsible party and date were determined prior to CCHSD changes and will be adjusted in future CHIP meetings.

## Chronic Illness - Strategies

Hub	Strategy	Associated policy change	Title of Responsible Party*	Early Milestones	Date*
Northern	Convene stakeholders meetings three times a year	None	Chief Health Officer	Schedule initial meeting for September 2013 and begin planning process	July 2013
Northern	Create community gardens	None	Program Manager for Arizona Nutrition Network	Schedule meetings with interested parties in Tuba City, Fredonia, and Page	September and October 2013
Northern	Teach health education in schools	None	Program Manager for First Things First and Arizona Nutrition Network	Continue nutrition and physical activity education with established curricula	Ongoing
Northern	Hold health fairs at workplaces and community events	None	Senior Manager and Health Educators in Page	Staff a booth with prevention specialists at the Back to School Fair	July 2013
Southern	Convene stakeholder meetings twice a year	None	Chief Health Officer	Schedule initial meeting for October 2013 and begin planning process	August 2013
Southern	Communicate grant opportunities to stakeholders	None	Grant Writer	Establish an email list of stakeholders by scope of work	Start date: July 1 <sup>st</sup> , 2013
Southern	Train service provider staff for increased efficacy	None	Grant Writer	Coordinate with the University of Arizona training	August 2013

\*Responsible party and date were determined prior to CCPHSD changes and will be adjusted in future CHIP meetings.

				programs to bring free trainings to Flagstaff	
<b>Southern</b>	Create gardens for exercise and food systems education	None	Program Manager for Arizona Nutrition Network	Schedule meetings with interested parties in Flagstaff and Williams	September and October 2013
<b>Southern</b>	Support the creation of worksite wellness programs	Adopting a county wellness policy and providing support for adoption by other worksites	Policy Analyst and County wellness team	Recruit fifteen small business owners to attend the Arizona Small Business Association's worksite wellness class	May 2013
<b>Southern</b>	Promote policy preventing chronic illness at the Hermosa Vida Policy coalition	Discussing feasibility of various chronic illness policy options	Policy Analyst	Collaborate with current Hermosa Vida policy coalition to promote Bushmaster Park's revitalization	April 2013
<b>Southern</b>	Advocate at the local and state level for chosen policies	Depending on group decision	Policy Analyst and the County Manager's office (for State level advocacy)	Meet with local leaders to propose at least one policy that will prevent chronic illness at the population level	May 2013

\*Responsible party and date were determined prior to CCPHSD changes and will be adjusted in future CHIP meetings.

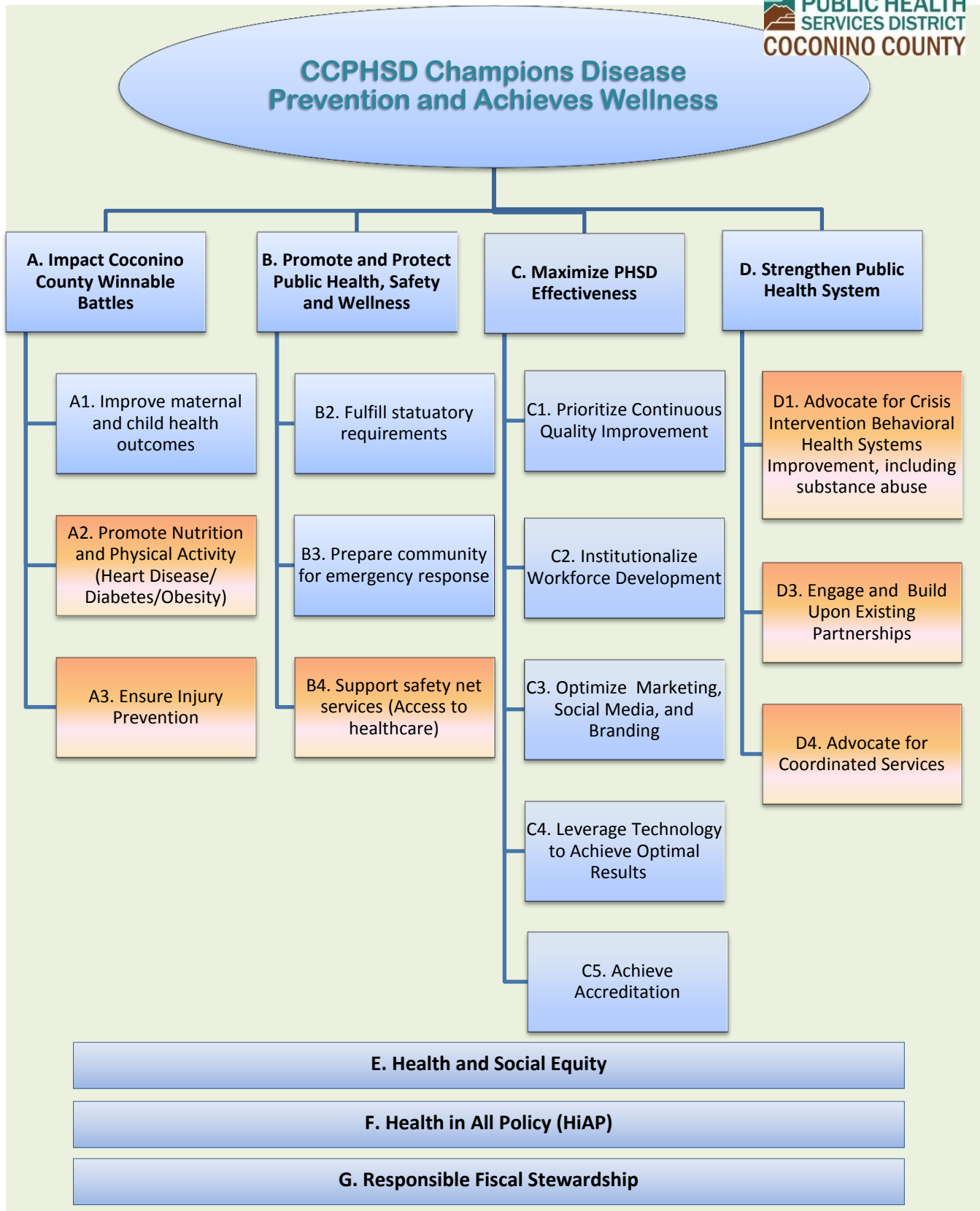
## Access to Care - Plan

Hub	Strategy	Associated policy change	Title of Responsible Party*	Early Milestones	Date*
<b>Northern and Southern</b>	Communicate grant opportunities to stakeholders	None	Grant Writer	Establish an email list of stakeholders by scope of work	Start date: July 1 <sup>st</sup> , 2013
<b>Northern</b>	Focus transportation issues on a route from Page to Tuba City and back	Encouraging Navajo Transit to add twice daily service between Page and Tuba City	Senior Manager in Page	Meet with decision makers at Navajo Transit	December 2013
<b>Northern</b>	Identify potential funding sources for regular medical transport vehicle	None	Grant Writer	Develop an initial list of potential grants and due dates	July 2013 and ongoing
<b>Northern</b>	Promote worksite wellness programs at schools and businesses	Facilitating memoranda of agreement between service providers and workplaces to provide basic wellness checks on site	Senior Manager in Page	Plan for MOU's with key stakeholders	September 2013
<b>Northern</b>	Create a list of all available low and no cost services	None	Administration Specialist and Senior Manager in Page	Contact all possible providers	August 2013
<b>Southern</b>	Convene stakeholder meetings twice a year	None	Chief Health Officer	Schedule initial meeting for September 2013 and begin planning process	July 2013

\*Responsible party and date were determined prior to CCPHSD changes and will be adjusted in future CHIP meetings.

<b>Southern</b>	Hold meetings with FMC and North Country Health Care during the ACA transition	Expecting policy change but unknown	Access to Care Senior Manager	Establish stakeholder roles for the ACA transition at the first meeting	October 2013
<b>Southern</b>	Train service provider staff for increased efficacy	None	Grant Writer	Coordinate with the University of Arizona training programs to bring free trainings to Flagstaff	August 2013
<b>Southern</b>	Support the expansion of the Northern Arizona Intergovernmental Public Transportation Authority	Encouraging NAIPTA to add service to outlying Flagstaff area	Policy Analyst and Access to Care Senior Manager	Meet with decision makers at NAIPTA to discuss future plans	May 2013

## Appendix D: CCPHSD Strategic Map 2014-2019



Strategic map created on April 30, 2014 by CCPHSD Senior Managers and subject matter experts, facilitated by Carol Vack and Patricia Tarango of the Arizona Department of Health Services. Orange boxes denote strategic directions shared with the Community Health Improvement Plan.